VERMONT
Agency of Human Services

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495
www.ovha.vermont.gov
[phone] 802-879-5900

Division of Health Care Reform
312 Hurricane Lane, Suite 201
Williston, VT 05495-2807
www.hcr.vermont.gov
[phone] 802-879-5988

Blueprint for Health
Vermont Dept of Health
108 Cherry Street , Burlington, VT 05402
health.vermont.gov
[phone] 802-879-5988

March 15, 2010

Charlene Frizzera, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Frizzera:

The State of Vermont applauds the excellent work the Centers for Medicare & Medicaid Services (CMS) has done, as well as its close collaboration with the Office of the National Coordinator for Health Information Technology (ONC), on the development of the proposed rule for the Medicare and Medicaid Electronic Health Record Incentive Program (the "Proposed Rule"). The task is enormous, the timelines are daunting, and yet the thoughtful, detailed quality of the rule making effort has been extraordinary.

As participants in the Statewide HIE Coalition, the Markle Foundation Connecting for Health Steering Group, and the National Association of State Medicaid Directors, we concur with and generally support the comments all three groups have submitted on the Proposed Rule, but wish to take the opportunity to highlight a few issues of particular importance from the Vermont perspective.

Vermont has led the nation with its systemic health care reform. At the same time that Vermont's coverage reforms have reduced the uninsured population from 9.8% in 2005 to 7.6% in 2009, the state has implemented a balanced set of delivery system reforms to ensure that those coverage improvements can be sustained. Health Information Technology (HIT) and Health Information Exchange (HIE) have been embedded in Vermont's health reform initiatives since 2005. The HITECH Act section of the 2009 Recovery Act articulates precisely the point Vermont reform has always made: *HIT is not about technology, it's about improving a system of care.*

Funding by the Medicare and Medicaid incentive payment programs, as well as from the Office of the National Coordinator (ONC), provides Vermont with a means to accelerate statewide adoption, implementation, and Meaningful Use of HIT, and as such, we fully support the goals of the Proposed Rule. Vermont was striving for meaningful use of HIT before Meaningful Use was identified as the central term and concept it has become. The State's role, wholly consistent with Federal policy, is to ensure every practitioner in Vermont has the opportunity to participate successfully in the CMS provider incentive programs and to do so in a way that further enhances State goals for health care delivery "systemness."

That having been said, we have concerns about the practicality of the timeframes for implementation of the Proposed Rule and for providers to achieve Meaningful Use within them. Even in Vermont, where we have a considerable head start on this work, the prospects for achieving broad based, successful provider participation in these programs will stretch already stressed State and provider resources to their maximum. The schedule outlined in "Table 1 – Stage of Meaningful Use Criteria by Payment Year," helps to address this concern by extending Stage 1 through 2014.

As or more significant than provider readiness is the issue of vendor readiness: as we have supported the development of interfaces connecting EHR systems to our statewide HIE, we again and again encounter the need for customized, "hand made" builds to achieve true interoperability. The more exacting, uniform standards being developed under the post-ARRA ONC structure to meet many components of the Proposed Rule's metrics and measurement are necessary, welcome, and overdue, but they remain a work-in-progress, further complicating the ability of providers to meet Stage 1 Meaningful Use in the near term. We support efforts from CMS and ONC to use their Certification Authority to ensure rapid development of truly interoperable interfaces to minimize this problem.

Again: the goals expressed in the Proposed Rule are totally on point; the concern is whether robust execution is possible in the near term without more clear direction to and expectations for the vendors. Our experience in a state that has been working more intensively in this area for longer than most indicates that it will be extremely challenging, given the state of EHR development and a business model that appears premised on incremental, cost-plus builds of additional features that should be standard from the outset. We believe it would send a significant, encouraging signal to the provider community for CMS to work closely with ONC to ensure vendors provide true interoperability in the same time frames providers are expected to demonstrate Meaningful Use.

Another area of particular concern to Vermont is the definition of Hospital-Based Physicians. Physicians who are employed by a hospital but practicing in primary care or other ambulatory care specialties who are not served by the hospital's EHR should be eligible for EP incentives, even if they bill through the hospital. In Vermont, hospitals employ approximately 65% of all physicians, but many of those practice at sites that are distant from the hospital and not served by the hospital EHR. As a State Medicaid agency, we would ensure that hospital-employed providers are not "double dipping" with eligible hospital incentives, but as written, the Proposed Rule would exclude that flexibility and not encourage broad physician EHR adoption.

Finally, we recognize that ARRA directs CMS to focus incentive payments on physicians and hospitals, but of course a great many Medicaid providers fall outside those two categories, and we hope that CMS will ultimately support incentives to expand HIT and HIE to the full continuum of provider types, organizations, and settings. To that end, we appreciate and applaud the flexibility CMS contemplates in supporting state efforts to extend HIT and HIE capacity to all Medicaid providers.

Improving quality of care through the implementation of HIT extends well beyond patient encounters with doctors and hospitals. Indeed, the evidence is that most successful health care improvement takes place during that majority of time when patients are not in their doctors' offices. Public health and prevention programs, as well as HIT-enabled patient self-management, are critical to improving our overall system of health. While the Proposed Rule's goals touch on those areas, the funding and support for integrated, interoperable HIT and HIE fall somewhat short of enabling fully comprehensive implementation.

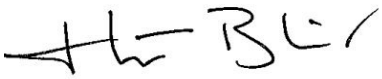
An overarching goal for Vermont delivery system reform is that the fragmentation of care should be a "Never Event." Good care requires coordination and integration, from primary care to specialty care, medical health to mental health, pediatric to geriatric care, across all settings, from institutions to homes, throughout daily life. While the Federal focus is on HIT deployment and HIE connectivity for physicians and hospitals, Vermont's vision includes a much broader spectrum of providers and individuals:

17	**VT Hospitals**	1 Tertiary Academic Medical Center, 8 CAH, 5 Community Hospitals, 1 VA Medical Center, 1 Private Psychiatric Hospital & the State Hospital
	Plus **Regional Hospitals**	adjacent NH, MA, NY Tertiary Hospitals, and access beyond via New England Telehealth Consortium
8	**FQHC Grantees**	operating a total of 40 primary care, dental, and mental health service sites
14	**Rural Health Clinics**	11 Family Practice and 3 Pediatric
240	**Primary Care Practices**	other GP, FP, OB/GYN and internal medicine practices
3,498	**Physicians**	with active Vermont licensure
503	**Dentists**	with active Vermont licensure
14	**Home Health & Hospice Agencies**	across Vermont; all non-profit community based, all with integrated Hospice.
16	**Community Mental Health Centers**	and Developmental Disabilities Agencies operating over 50 sites
2,412	**MH/BH/SA Counselors**	licensed private mental health/behavioral health/substance abuse counselors; clinical social workers, psychologists and other professionals
250+	**Long Term Care and Public Housing sites**	including Nursing Homes, Residential Care Homes and Assisted Living Facilities, Adult Day, Meals on Wheels, and Congregate Living sites.
9	**Dept. of Corrections sites**	to be linked via a common EHR and MHISSION-VT infrastructure
12	**District Health Dept. and Agency of Human Services Offices**	including participation of local Public Health staff, social & human services staff, as well as Agency and Department Central Offices
And	**621,270 Vermonters**	whether privately insured, publicly insured, or uninsured

Meaningful Use of HIT should, as it matures over time, touch all of these institutions, professionals, and individuals. The State of Vermont, in partnership with CMS and ONC, welcomes the opportunity to advance this transformative vision of improving health care quality and performance through the thoughtful, collaborative, and intentional implementation of HIT and HIE.

Thank you again for the leadership CMS has taken on in this area. Together, states and our federal partners have a fabulous opportunity to advance the quality and care Americans receive from their health systems with enabling technology, and we look forward to the challenges ahead bringing a shared vision to fruition.

Sincerely yours,



Hunt Blair
Deputy Director for Health Care Reform
and State HIT Coordinator